

ANATOMICAL PATHOLOGY



ALPHA LABORATORIES INC.
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DATE OF SERVICE	LAB ACCESSION NUMBER
D M Y	

SPECIMEN CONTAINER(S) MUST BE LABELLED WITH PATIENT'S FIRST & LAST NAME, D.O.B. PLUS NATURE OF SPECIMEN

REQUISITIONING PHYSICIAN'S NAME AND ADDRESS	HEALTH CARD NUMBER	VERSION	DATE OF BIRTH	PAYMENT PROGRAM
	D M Y		D M Y	
	PROV.	OTHER REGISTRATION	PATIENT'S PHONE NO.	
			()	
	PATIENT'S NAME			SEX
	LAST	FIRST	MIDDLE	
REQUISITIONING PHYSICIAN NO.	PATIENT'S ADDRESS			
PATIENT'S REFERENCE NO.	CITY	PROV.	POSTAL CODE	
COPY TO: ADDRESS:	COPY TO: ADDRESS:			

SITE OF BIOPSY	BIOPSY NUMBER

CLINICAL INFORMATION

RELEVANT CLINICAL HISTORY:
 RELEVANT THERAPY:
 PRE-OPERATIVE DIAGNOSIS:
 POST-OPERATIVE DIAGNOSIS:
 PREVIOUS HISTOLOGY OR CYTOLOGY NOS:

COLLECTION DATE:	COLLECTION TIME:	TIME IN FIXATIVE:
PHYSICIAN'S SIGNATURE:	DATE:	

- FOR LABORATORY USE ONLY -

Received Date: _____ Time: _____ ^{AM}/_{PM} # of Bottles Received: _____ Received By: _____

<input type="checkbox"/> Specimen received unlabelled	<input type="checkbox"/> Site of biopsy not provided
<input type="checkbox"/> Specimen received without formalin	<input type="checkbox"/> Specimen does not match requisition
<input type="checkbox"/> Specimen received with insufficient formalin	<input type="checkbox"/> Other (specify) _____

FOR LABORATORY USE ONLY

LAB ACCESSION #

GROSS DESCRIPTION											INIT AND DATE

CASSETTES / LEVELS											TECH INIT AND DATE
SPECIMEN	CASSETTE #	LEVEL	CASSETTE #	LEVEL	CASSETTE #	LEVEL	CASSETTE #	LEVEL	CASSETTE #	LEVEL	
A											
B											
C											
D											

STAINS											TECH INIT AND DATE
<input type="checkbox"/> H & E		<input type="checkbox"/> PAS		<input type="checkbox"/> PAS / D		<input type="checkbox"/>					
<input type="checkbox"/> TRICHROME		<input type="checkbox"/> GIEMSA		<input type="checkbox"/> PPB		<input type="checkbox"/>					
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>					

ADDITIONAL PROCEDURES REQUESTED BY PATHOLOGIST											INIT AND DATE

<input type="checkbox"/> REFER FOR CONSULTATION											INIT AND DATE
TO											
AT											

DIAGNOSTIC EXAMINATIONS										
<input checked="" type="checkbox"/> L720	SURGICAL PATHOLOGY				<input type="checkbox"/> L866	SURGICAL PATHOLOGY – LEVEL 6				
<input type="checkbox"/> L861	SURGICAL PATHOLOGY – LEVEL 1				<input type="checkbox"/> L867	SURGICAL PATHOLOGY – UNLISTED SPECIMENS				
<input type="checkbox"/> L862	SURGICAL PATHOLOGY – LEVEL 2				<input type="checkbox"/> L868	SPECIAL HISTOCHEMISTRY FOR IDENTIFICATION OF MICROORGANISMS				
<input type="checkbox"/> L863	SURGICAL PATHOLOGY – LEVEL 3				<input type="checkbox"/> L869	SPECIAL HISTOCHEMISTRY FOR IDENTIFICATION OF ELEMENTS OTHER THAN MICROORGANISMS.				
<input type="checkbox"/> L864	SURGICAL PATHOLOGY – LEVEL 4				<input type="checkbox"/> L731	IMMUNOPEROXIDASE TECHNIQUE: # LABELS _____				
<input type="checkbox"/> L865	SURGICAL PATHOLOGY – LEVEL 5									

PATHOLOGIST'S SIGNATURE:		DATE:	
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